Town of West Hartford Dial-A-Ride

Fee Waiver Form for a Medically Necessary DAR Companion Rider

Dial-A-Ride Passenger

Name: _____ DOB: _____

Dial-A-Ride Companion Rider

Name: _____ DOB: _____

Emergency Contact Information

Name: _____

Relationship: _____ Phone #: _____

Physician Information

Physician Name: _____ Phone #: _____

I, Dr. _____, hereby certify that the Dial-A-Ride passenger named above has a medical condition and/or a disability which prevents them from being able to safely negotiate a Dial-A-Ride service bus without the benefit of a companion to ensure their safety.

_____ _____

Physician's Signature **Date**

Mail or fax completed form to:

West Hartford Dial-A-Ride
50 South Main Street, Rm. 306
West Hartford, CT 06107
Fax: 860-561-7577